WITS HEALTH CONSORTIUM
Wits Health Consortium (Pty) Ltd
Reg No.: 97/15443/07

Rural Health Advocacy Project

Rural Health Advocacy Project: 2022 Division of Revenue Proposal

Submission to Appropriations Committee

Executive Summary

This submission serves as the Rural Health Advocacy Project's (RHAP) contribution to Parliament's call for input on the 2022 Appropriations Bill. Significant resource constraints define the foreseeable future. Yet little clarity is provided on how ongoing inequalities and inefficiencies in existing health spending are to be addressed. Unless these fault lines are confronted, South Africa's healthcare system will remain fragile regardless of resource availability. Where the Covid pandemic has wrought devastation, recovery efforts in its wake presents a vital opportunity to rebuild differently.

As RHAP, we see government's responsibility as ensuring the optimization of current health spending to secure a more equitable access to primary healthcare (PHC), towards universal health coverage (UHC). This requires a human rights budgeting framework which more intentionally aligns economic policy with socioeconomic rights. We argue that building resilient rural health systems is inseparable from this aim. Rural-proofing our current policies challenges core features of persistent inequalities, while improving access to health for the majority of underserved or excluded. Such processes are not simple. However, immediate steps towards realising ethical and efficient budget prioritisation can and must be taken. To this end, we recommend a joint committee of the appropriate governmental bodies and civil society members to call for active review of planned provincial health budget allocations relative to the actual needs faced.

Table of Contents

Introduction

As we emerge from the emergency into the seemingly endemic phase of the COVID-19 pandemic, the enjoyment of the right is confronted by a deep inequality of access and healthcare system in need of renewal. Our health needs are vast and our resources are sparse. This was true before Covid, and only more so now. Section 27 of the Constitution guarantees access to healthcare to everyone, including reproductive health services. Yet South Africans' health needs outstrip the capacity of their healthcare systems. This poses the clear dilemma: how is the government to meet its Constitutional obligations with regards to health within the context of limited funds?

Without enough funding, we cannot do everything at once. Options to resolve this include raising further finances, reprioritisation from other budgets, or considering the totality of healthcare spending over public and private sectors - as partially envisioned by the National Health Insurance. Yet potential for doing so is limited. The consequent consideration is revising how existing funding is used towards optimising its impact. With a healthcare system defined by significant inequalities, fragmentation and inefficiencies, this focus is imperative for South Africa. Working within limited, existing funding then requires explicit budget prioritisation and framework for doing so.

Realising the right to healthcare access must be understood through achieving Universal Health Coverage; defined by access, quality and affordability of healthcare for all. The theme for 2021's UHC Day was "investing in health systems for all, to ensure that no one's health is left behind"[1]. This presents a simplified principle of prioritisation, as recommended by the World Health Organisation: that adequate healthcare services must be extended to the most vulnerable before anything else. For South Africa, this requires greater investment in primary healthcare services, and focuses primarily on rural areas which suffer historical and ongoing low service coverage. Rethinking how an adequate healthcare workforce, relevant health information systems and responsive budgeting mechanisms can be coordinated under good governance and values offers the possibility of building resilient health systems, reducing vulnerability to shocks and deepening South Africans' health and wellbeing.

Yet the 2021 State of the Nation Address, given by president Ramaphosa, gave no indication of how the current state of healthcare services are to be protected, let alone improved, despite the rising challenges. The 2022/23 budget, as announced by National Treasury, again raises concerns in this regard. Nonetheless, the numbers are only half the story. How exactly they are allocated, to where and why, paints a more important picture of what is being prioritised and what is possible. To this, we strongly recommend that the budget decision-making being carried out by provincial departments of health be examined to assess whether the rationale meets their local realities.

An Unequal Health System

South Africans' access to healthcare is profoundly unequal not merely due to resource constraints, but also due to a highly skewed distribution thereof. This stems from uneven

[1] UHC Day 2021 - We must invest in health systems that leave no one behind - UHC2030

resource distribution between the public and private sector, as well as within the public sector. The public-private divide, respectively serving 80% vs 20% of the population, is starkly highlighted with overall healthcare spending being split roughly 50:50 between them. Internal distributive disparities create substantial inefficiencies due to little correlation between budget allocations and local population needs. These unequal and inefficient distributions drive inequity in access to healthcare and health outcomes.

The impact of and response to Covid provided a transparent case study in this regard. Without having built a more equitable health system prior to the pandemic, and in the absence of effective regulation during, we saw inequality of access define the Covid response; including diagnoses, treatment, mortalities and, ultimately, access to vaccines - as well as impact on longer-term disease burden. Some of the effects are considered below

In respect of testing: of the over 22 million diagnostic tests carried out, over 54% were conducted in the private sector[2]. Given that only 15% of the population (including government employees) have access to private medical insurance, we can deduce that many of these tests were paid out-of-pocket. Despite this financial vulnerability, private pathology firms were left to profit off of inflated prices for polymerase chain reaction (PCR) test until the Competition Commission was pushed to confront pricing in October 2021; while price-setting for rapid antigen testing kits remains untouched[3].

Cumulatively, 499 595 people were able to access Covid treatment across 403 public and 250+ private health care facilities. Net admissions were marginally higher in the public sector, yet this represented a notably low patient admission rate relative to the number of hospitals and the population served. Private hospitals, who primarily cater for patients to enjoy medical aid, were responsible for close to 46% of all Covid-related admissions – with an average cost of 85 000 ZAR per admission[4]. In effect, state failure to regulate the health system's response effectively made access to Covid care dependent on ability to pay, rather than need.

By March 2022, just over 17 million South Africans, or 43% of the adult population, were fully vaccinated[5]. This represents a marked increase in rates of vaccination over the last months, yet far short of the national goal of 70% by the end of 2021. The vaccination rollout has faced numerous obstacles, with heavy debate on the role of vaccine hesitancy. Notably, vaccine acceptance actually increased from 67% to 72% over 2021[6]. Divides between urban and rural tell an important story. Where vaccine acceptance sits at 69% and 78% for urban/suburban versus rural and informal settlements, urban areas exhibit greater vaccination rates[7]. This points to significantly uneven access. The "tyranny of distance" faced in rural areas, with major challenges

---

2 Latest Confirmed Cases Of COVID-19 In South Africa (22 February 2022)

3 https://www.compcom.co.za/wp-content/uploads/2021/12/PATHCARE-ALSO-AGREES-TO-AN-IMMEDIATE-PRICE-REDUCTIONOF-COVID-19-PCR-TESTS-FINAL.pdf

4 Covid-19 hospital admissions cost Discovery R85 000 on average - Moneyweb

5 Latest Vaccine Statistics - SA Corona Virus Online Portal

6 UJ-HSRC COVID-19 DEMOCRACY SURVEY Vaccine acceptance and hesitancy

7 Vaccine hesitancy takes on a whole new dimension in SA - Health-e News

to delivering health services to populations characterised by high sparsity, presents a clear obstacle here[8]. This, in turn, highlights a key weakness in some rural areas: our healthcare networks are not distributed according to need and access. Reliance on hospitals as vaccine centres created major challenges; in the context of excessive unemployment, even minor transport costs become prohibitive to access.

When we consider deaths from Covid the inequity deepens. Among the leading co-morbidities were uncontrolled diabetes and hypertension. In respect to the former, there is very little routine screening for diabetes. The 2018/9 District Health Barometer estimated that around 4,5 million people were living with diabetes; with just 1,2 million currently on treatment. Data from the Western Cape indicated that people living with tuberculosis (TB) were also three times as likely to die from Covid-related illnesses. Currently over 450 000 contract TB each year, while only 350 000 of these are initiated into the TB CARE treatment programme. Outstripping reported Covid deaths of 100 000, reliable estimates place Covid as a related cause of death for up to 95% of the total 300 000 excess natural deaths over this period. Given that majority official deaths carried these comorbidities, it is likely this trend held for the total excess deaths. In light of the large diagnosis and treatment gaps for NCDs and other health conditions such as TB, many of these deaths may have been avoided if the country had not delayed the strengthening and responsiveness of primary health care networks in the years preceding Covid to close these gaps.

While the debates on the risk-management efficacy of lockdowns will no doubt continue, we do know how these impacted the availability of primary health care services. The NIDS Cram study, exploring the unintended consequences of lockdowns, reported sharp declines in routine childhood vaccinations, HIV testing and TB case finding. The latter was confirmed in the most recent world TB report, which shows for the first time in a decade TB case finding has dropped sharply, while TB deaths rose.

The impact of this will carry a disproportionate longer-term cost on poor and rural communities in terms of lives and healthcare costs.

Previous Budget Trends in Health

Significant progress on investment and outcomes was made in health from 1994 to 2012. Stagnant economic growth following the 2008 global recession in the face of rising debt servicing costs stymied this. Healthcare spending continued increasing in real terms by average of 2.3% from 2012/13 to 2019/20. Yet per capita healthcare expenditure in provinces remained the same or fell over this period. Higher-than-inflation cost increases in human resources and rapid HIV/Aids programme expansion absorbing most of the increases. Notably, as explored by National Treasury in 2021, wage increases account for 75% of rising human resources spending since 2006/7, with only 25% due to increased headcount[9].

[8] 'The Tyranny of Distance': How to Vaccinate South Africa's Most Remote Villages

[9] 2022 Budget Review. National Treasury, RSA. 2022.

Some effective cost-saving measures have been made through active prioritisation in the face of increasingly constrained health budgets. This including identifying non-negotiables, prioritisation of PHC, refocus from building to maintenance of existing infrastructure, focus on health outcomes, centralised procurement of medicines, capping of headcount in human resources and other[10].

At the same time, certain links between prioritisation choices and efficiency of outcomes remain underdeveloped. This includes: dangers of capping HR numbers and, beyond significant impact on health outcomes, resultant impact on rising medico-legal claims (which, in turn, often further reduce funding for HR in order to be paid); maldistribution of staff creating mismatch between need and supply; potential oversupply and maintenance of hospital platforms within same areas despite low bed occupancies; lack of effective information to determine whether decreasing utilisation rates in clinics present a success of the Central Chronic Medicines Dispensing and Distribution programme, or decreasing perceived utility of and community trust in clinics (significant rates of patient-without-referral at hospitals in certain areas, however, suggests an overburdening of and unnecessary costs to hospitals by cases meant to be absorbed by frontline PHC networks. Whereas estimates of 45% of under-5 deaths occurring outside of health facilities indicates inadequate coverage of such networks[11]).

Low economic growth has continued to constrain government revenue and challenges of managing mounting cost pressures while maintaining efficiency and access. Increasing health needs via population growth, rising disease burden of non-communicable diseases and other heighten this situation, creating an increasingly overburdened and underfunded sector. The impact of Covid-19 has greatly exacerbated this. Government response meant substantial increases in health budget, but this entailed a necessary re-prioritisation on the Covid response. The pandemic has meant substantial delays for a National Health Insurance (NHI) meant to resolve key health funding inadequacies and inequalities, delayed maintenance of vital infrastructure, costly HR distribution based on Covid-burdens not necessarily related to ongoing needs, loss in progress on addressing the quadruple burden of disease, and many other areas.

Our commitments to the Sustainable Development Goals include UHC, understood as: "achievement of universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[12] By 2016/17, our UHC Service Coverage Index (which excludes financial risk protection) was calculated at 56.9, versus the global average of 66 and 2030 goal of attaining full coverage at 100.[13] Effects of Covid will have certainly regressed even this level of progress.

---

10 Health spending at a time of low economic growth and fiscal constraint. Blecher, M. 2017

11 Reducing neonatal deaths in South Africa: Progress and challenges. Rhoda, N. 2018.

12 SDG Target 3.8 | Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

13 Is South Africa closing the health gaps between districts? Monitoring progress towards universal health service coverage with routine facility data. Day, C. 2021.

Greater funding for health is needed to reverse the decline in health services; let alone to improve the access and quality thereof towards UHC 2030 goals. Certain areas for redirecting funds from other departments or raising state budgets may be possible. Yet the scope for doing so remains narrow; while healthcare itself also represents just one of many essential priorities competing for resources within a constrained financial landscape. This limits expectations for substantial additional state spending towards health in the short-to-medium term.

The challenge, then, is whether or how the 2022/23 budget and accompanying health sector strategies can create effective post-pandemic recovery in the face of these multiple pressures. What is painfully clear is that we cannot do so by simply reverting to pre-pandemic strategies as if the landscape has not changed.

Unpacking Implications of the 2022/23 Budget

Overall, the 2022/23 budget and Medium-Term Expenditure Framework (MTEF) reflects an accelerated commitment to fiscal consolidation; with focus defined by reduction in budget deficits and debt-to-GDP ratio stabilisation. Allocations to health stay relatively the same at 2020/21 levels, seeing a 1% increase for 2022/23, with a 0.2% growth over the MTEF period. In real terms, this means consolidated healthcare expenditure falls by 4.3% (before accounting for estimated increases in healthcare users), and a 15% decrease in per person expenditure over the MTEF. We can assume these declines are partially due to subsiding Covid-related costs. Nonetheless, this leaves little room to strengthen the responsiveness of the system to resolve health inequities unmasked during the pandemic.

Below we consider key outcomes from the 2022 budget and their potential impacts or challenges faced.

Provincial Allocations

We are glad to see our engagements with government around the need for more responsive provincial allocations bear fruit in the proposed changes to the health component of the Equitable Share Formula. The new variables used to calculate the risk-adjusted index (sparsity, multiple deprivation index, premature mortality, and total fertility rates) introduce weightings sensitive to the greater burdens carried by rural areas. These changes may not be enough to correct for the significance of inequities between rural and urban, however this is a step in the right direction. Whether this translates to greater health outcomes remains dependent on efficiency of spending.

Provincial allocations, overall, see an additional R15.6 billion allocated over the MTEF. This increase is set to primarily cover budget shortfalls driven by increased HR compensation, as well as to fund ongoing Covid response such as further vaccination rollout.

Primary Healthcare Services

The lack of new funding for PHC is worrying, given the dire need to address regression in screening, testing and treatment rates for infectious and non-communicable diseases caused by Covid. How this will be addressed by provincial departments of health remains to be seen.

Human Resources

Furthermore, without increased funding to hire additional healthcare workers, the freeze on filling critical and vacant posts is set to continue. Treasury directly recognises this in stating that the budget is "limiting the ability of provincial health departments to employ more frontline staff"[14]. This poses specific risks such as increased vulnerability to increasing medico-legal claims, but also curtails potential efficiency of outcomes across all health programmes. Treasury further recognises the danger posed here by recommending a review of policies around staffing norms in regards to affordability.

A welcome R3.3 billion over the MTEF is allocated to funding medical interns and community service doctors requiring placement. Previous budgetary constraints have delayed fulfilment of this statutory obligation. An inability to absorb healthcare workers funded through the health science and training budget presents a major source of inefficiency; effectively pouring expenditure into an invaluable investment that cannot be used. Changing this enables a potential lifeline to an under-capacitated workforce, depending on whether their placement is able to counteract the existing maldistribution versus substantial need. The National Human Resources for Health Strategy provides some options on how this can be done to advance equity.

Infrastructure

Reprioritisation of funding meant for health infrastructure is made to help increase allocations to human resources. This continues the trend of cuts in this area, often justified on the basis of significant historical underspending. Nonetheless, significant funds do remain available for much needed but delayed projects. However, various issues, such as frequency of overspending in procurement processes, point to need for greater oversight. More clarity as to the actual priority lists for projects within provinces is necessary to ensure investments are justified according to improving service delivery coverage.

District Health Programmes Grant

Changes see the HIV, TB malaria and community outreach grant reconfigured and renamed as the district health programmes grant; with R1 billion added to the Covid-19 response component to cover additional vaccine purchase. This sees mental health and oncology services components being moved to the direct national health insurance grant. The given justification for this being that "provinces have shown readiness to take on the delivery of these services". However, as of yet, no indication is given as to how these essential services are to be carried out, risking whether the funds shifted along with them will be protected for their use and effectively utilised.

Beyond this, the new grant apparently retains a similar function as previously. The reduction in funding over the medium term poses likely risks of failure to meet our 90/90/90 goals for HIV/Aids. Yet this may present an opportunity to review and refocus the retained components as well as strengthen their implementation.

National Health Insurance Direct Grant

[14] 2022 Budget Review. National Treasury, RSA. 2022.

The NHI direct grant is to increase access to quality healthcare services through strategic contracting of healthcare providers. This being a part the strategy to progressively realise UHC during the phased implementation of the NHI. Allocations for the grant increase significantly from R246 million in 2020/21 to R694 million in 2022/23, this largely due to incorporating services of mental health and oncology, and the funding for them, within it.

Underspending rates remain fairly low, with 94.2% or R232 million of the grant spent in 2020/21. Furthermore, allocations require comprehensive business plans from provincial departments, and are based on criteria largely aligned with identifying greatest need. Despite this, relative impact of expenditure and room for improvement remain questioned. Across 2020/21, main output was 233 health professionals contracted; this suggesting significantly high per unit costs. High compensation is expected with regards to goals of securing highly qualified services. On the other hand, focus should be given to whether there is room to improve plans to produce maximised impact for more healthcare users, and to ensure these are effectively integrated with existing services?

National Health Insurance Indirect Grant

The NHI indirect grant, on the other hand, is designed to directly prepare the health system for the implementation of an NHI, with 3 components: non-personal services, personal services, health facility revitalisation. These involve a number of focuses, including: testing of innovative reforms, investing in adequate health infrastructure, development of necessary health information systems (HIS), support for alternative medicine dispensation methods, and strengthening primary healthcare. This sees R2.2 billion for 2022/23.

Certain challenges with underspending have existed; the Personal and Non-Personal Services components spending 81% and 85.5% respectively of 2020/21 allocations. The appointment of the deputy director-general for the NHI may help address these shortcomings. This funding, in particular, offers significant potential to improve the capacity, responsiveness and sustainability of publicly funded healthcare. Previous NHI demonstration projects carried varying success. Yet, if managed well, funding for further demonstration projects and strengthening of PHC could deliver significant improvements in district health services and efficacy of care networks, substantially advancing progress towards UHC.

Additionally, health information systems development is vital. Recent research by the Medical Research Council revealed that about 40% of public hospitals were unable to produce accurate discharge records[15]. Without this basic level of routine HIS, hospitals cannot support the resource management and reimbursements required for NHI. Moreover, the availability of timely, relevant and sound data is foundational to public health decision-making. Any attempts towards improving efficiency, evaluating priorities or progress, applying good governance and enhancing accountability, are critically dependent on the functionality of our health information systems. How we are strengthening this is vital to the project of building back better.

[15] Is the routine health information system ready to support the planned national health insurance scheme in South Africa? | Health Policy and Planning | Oxford Academic

Bridging the budget to impact

Certain progress is made by the 2022 budget. Yet continued budget constraints placed by the budget maintain the core dilemma: health needs increasingly outstrip healthcare capacity, without the possibility of substantial additional funding to resolve this. In this context, trade-offs are inevitable. How these are made will determine the strength and effectiveness of the post-pandemic recovery plan towards resilient health systems.

For this, the numbers on their own mean nothing. As we have tried to explore above, the real impact made possible by this budget will be entirely determined by the choices guiding their subsequent allocations and implementation. We argue that optimising these choices requires an explicit framework of prioritisation. National Treasury itself recognises this key shortcoming of the budget, and the struggle ahead, in stating that: "nonetheless, provinces and municipalities will need to improve efficiency and spend more effectively to fulfil their mandates – including through the implementation of findings from spending reviews. This requires political will, good governance and better financial controls".[16] Realising greater efficiencies while managing budget pressures is a complex and ongoing task. The present challenge is establishing how this responsibility can be better supported in the short-term to ensure a progressive realisation of rights to healthcare access.

Where overarching guidelines and oversight is located nationally, provinces are largely responsible for the country's healthcare through expenditure based on their allocation decision-making. One-size-fits all models enforced top-down is undesirable, given contextual factors. Furthermore, research proves an inconsistent relationship between increased health programme expenditure and health outcomes across provinces; highlighting important disparities in efficiency to interrogate and need for approaches tailored to individual provinces.[17] However, as explored above in historical trends, budgetary-decision making within provincial departments are liable to maintain existing inefficiencies. As recognised previously by Treasury, provincial departments' allocations often become based on historical expenditure trends as opposed to clear links to plans, targets, or changes in programme performance.[18] Hence, existing provincial autonomy should be upheld, yet room to potentially review and enhance their annual performance plans should be explored beyond existing accountability mechanisms.

To this end, a temporary joint committee of appropriate governmental bodies and civil society actors should be established to review presentations from provincial departments with specific focus on how budget allocations are effectively responding to provincial health needs in the wake of Covid.

Recommendations

Despite the multiple pressures faced, we believe substantial grounds exist for progressively realising South Africans' Constitutional right to health within current constraints. With limited funds, we cannot do everything at once. However, government's obligation to this right should

---

16 2022 Budget Review. National Treasury, RSA. 2022.

17 Has South Africa's Investment in Public Health Care Improved Health Outcomes? | Economic Research Southern Africa

18 https://www.who.int/health_financing/events/D2S2-Blecher-budget-structure-and-trends-South-Africa.pdf?ua=1

be understood as prioritising a more equitable access to healthcare for the majority. In our context, this primarily requires a greater focus on expanding and/or reconfiguring primary healthcare provision towards universal healthcare coverage. To do so is a complex and long-term project; being critically dependent on timely and relevant health information that allows evidence-based approaches, as well as effective governance to take advantage of this. Yet to start requires making explicit how decision-making is informed by a human-rights based budgeting framework guided by core considerations of ethics and efficiency; representing, at its most simple, an alignment between allocation and need.

One step towards grasping this opportunity in the present, is in supporting a review of provincial departments' planned usage of funds in 2022/23. This presents a valuable opportunity to: assist further inter-provincial learning of how health managers can protect healthcare for the majority in trying times, and enhance the efficiency of annual performance plans.

<u>As RHAP, we strongly recommend to the Standing Committee on Appropriations, that:</u>

- A joint committee to be set up temporarily to review and interrogate provincial departments' budgetary decisions for 2022/23, in accordance with most optimally aligning allocation of available resources to meeting existing needs.
- This committee should be jointly comprised of the: National Department of Health, Portfolio of Health, National Council of Provinces, and Civil Society Actors in the scope of health
- Appropriate representatives from provincial departments, such as the head of departments, should engage with this committee to present on and explain how their allocations, given by their annual performance plan, are intentionally prioritising efficient coverage for the most vulnerable.

This is one small step, yet making budgetary processes transparent and accountable to a human rights framework goes towards longer-term objectives of resilience building. We believe this perspective is indivisible from the task of rural-proofing our recovery for more resilient healthcare systems, given that the primary sources of inequity manifest between rural and urban, and within rural areas themselves. However, this stands to strengthen health systems nationally.

For further information, please contact RHAP at:

- Nathan Taylor [redacted]
- Russel Rensburg [redacted]